

## HEALTH RISK SCREENING

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Assessor/Title: \_\_\_\_\_

Mission Statement: Evaluate and mitigate the risks associated with health issues.

Question:	Yes	No	Code
1. Individual has profound level of MR?			
2. Individual is dependent of staff for 25-75% of oral intake?			
3. Individual has enteral feeding?			
4. Individual had pneumonia in the last year?			
5. Individual had 10 or more seizures in the last year?			
6. Individual takes 2 or more antiepileptic drugs?			
7. Individual takes AED & Psychoactive medications?			
8. Individual takes 2 or more psychoactive medications?			
9. Individual diagnosed with Tardive Dyskinesia?			
10. Individual diagnosed with osteoporosis?			
11. Individual has ever had a long bone fracture?			
12. Individual has insulin, non-insulin, or controlled diabetes?			
13. Individual diagnosed with chronic constipation?			
14. Individual diagnosed with congestive heart failure?			
15. Individual has had a stroke or hemiplegia?			
16. Individual diagnosed with hypothyroidism?			
17. Individual diagnosed with essential hypertension?			
18. Individual diagnosed with gastro esophageal reflux?			
19. Individual had any restraints in the last 6 months?			
20. Individual unable to ambulate independently OR ambulates with assistance or assistive device?			
21. Individual is incontinent?			
22. Individual had dehydration in the last year?			
23. Individual has Hyponatremia or Hypernatremia?			
24. Individual had a weight change of plus or minus 5% in 1 month?			
25. Individual has Braden score that is high risk (<=12)?			

Code (information from):

1	IPP
2	Medication Administration Plan
3	Current Assessment (within the last year)
4	Nursing Care Plan
5	PNM Plan
6	Other (please write in)